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ABSTRACT

The role of counselors in working with chronically health impaired students is examined, and illustrations of the Chronic Health Impaired/Sickle Cell Anemia Program in Baltimore (MD) are presented. The importance of setting goals with the student is underlined, as is the necessity for counselors to have proper flexibility and time to devote to clients. the students' special emotional, social, educational, medical, and vocational needs are considered, as are the needs and reactions of parents and families of chronically health impaired students. The counselor's relationship to other agencies and professionals is explored. Case studies of students with asthma, epilepsy, and sickle cell anemia conclude the handbook. (CL)

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COUNSELING THE CHRONICALLY HEALTH IMPAIRED STUDENT

The Chronic Health Impaired Demonstration Project
ESEA, Title IV, Part C
Division for Exceptional Children
Home and Hospital Instructional Services
Baltimore City Public Schools

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FORWARD

What is CHIP?

The Chronic Health Impaired/Sickle Cell Anemia Program (CHIP) is an innovative home teaching program operated by the Baltimore City Public Schools. CHIP provides a variety of educational services to children with such illnesses as:

-asthma
-arthritis
-cystic fibrosis
-diabetes
-epilepsy
-hemophilia
-kidney disease
-sickle cell anemia

A student in the CHIP program is taught at home only on the days he is too sick to attend his regular school. These absences are usually for only a few days at a time, but they occur frequently throughout the school year. CHIP students also receive remedial teaching to compensate for previous absences, a variety of counseling services and tutoring if needed.

Family support is crucial in the successful adjustment of chronically ill children. CHIP assists families by providing programs for parent education, family counseling and resource referral services.

Public Law 94-142 mandates services to students with chronic health impairments. It defines the physically handicapped in two categories: orthopedically impaired and other health impaired which are characterized by limited strength, vitality or alertness, due to chronic or acute health problems.

This manual has been written by counselors in the Baltimore City Schools who work daily with chronically ill students. Its purpose is to alert other counselors to the needs and problems of this client population and to clarify the vital role that counselors play in the Chronic Health Impaired/Sickle Cell Anemia Program.

The booklet is our component of the Chronic Health Impaired Demonstration Center, a federally funded project (ESEA IV) that is an outgrowth of the Chronic Health Impaired/Sickle Cell Anemia Program. The demonstration project is designed

to assist other school systems to set up educational programs for chronically ill students.

INTRODUCTION TO COUNSELING THE CHRONICALLY ILL STUDENT

Counselors, social workers, psychologists, and other "helping professionals" assume additional responsibility when beginning services to the chronically ill. This client population can present a variety of difficult problems and needs.

The first step in any counseling situation is the establishment of the client/counselor relationship. This is also the case when working with the chronically health impaired client.

Chronically ill children may, at first, appear reluctant to engage in any type of relationship with a counselor. The young child may view the counselor as yet another adult, who, by entering his life, will bring additional pain and suffering. It should be kept in mind that such a child has experience with medical personnel, who the child may associate with pain because of his illness or the treatment.

The elementary school child may have difficulty in understanding the different functions of various professionals. In the mind of the child, the counselor may be viewed as a doctor making a home visit. The counselor in the Chronic Health Impaired Program (CHIP) must devote considerable attention to clarifying his role to the child.

Setting Goals

Counselors of the chronically ill should not engage clients without establishing specific goals, as the presence of such a professional clearly elevates the expectations of the child. The ego of the chronically ill child is fragile; therefore, intervention must be of a constructive and measurable dimension. Such children should not be subjected to false

expectations or unrealistic goals.

This is not to say that goals set for such students must necessarily be restrictive. Too often, the professional is guilty of expecting far too little. We know that research has demonstrated that achievement is closely linked to expectancy. While it is vitally important that counselors fully understand the medical limitations of each child, each student must be encouraged to establish high personal, educational, and vocational goals.

Goal setting serves several important functions. It begins the process of self-examination for the child and causes the child to look at what is going well in his life and what is not. It brings into focus that which he seeks to change and that which he seeks to protect.

Secondly, the establishment of goals provides the counselor with the opportunity to demonstrate his acceptance and faith in the ability of the child to make significant decisions. Remember, it is the child who must utimately decide upon the areas he feels need the help of his counselor. The counselor's role is not that of a decision maker.

Goal setting also provides structure to the counseling schedule. Such goals provide a necessary starting point and aid in the eventual process of termination.

Working With The Client

A primary task of counseling with this clientele is to facilitate the growth of attitudes which promote the development of a positive self-image. The self-image of the chronically ill child demands the attention of counselors, because prolonged illnesses have demonstrated a seriously destructive effect upon the egos of such children.

For the chronically ill child, personal growth and development may be awesome in its complexity. Otherwise normally acquired social behaviors may

not be attained by the bedridden child who has little or no contact with peers. Such a child may exhibit adult-like behaviors, as his only models have been those of his parents. While his behaviors are accepted within the framework of an adult population, what then happens to such a child who finds he is now able to again attend a regular school?

Such a child, through the help of a counselor, may see the need to work on behaviors which are likely to meet with peer group approval. The CHIP counselor can serve a vital function in assisting the child to develop new behavior, while offering to the child support for his efforts.

In working with the chronically ill child, it is important that both the child and his family achieve a high degree of acceptance of both the illness and the effects such an illness has on the larger family unit. Therefore, counseling must be viewed as a family service, and the counselor must actively seek the involvement of the family.

A myriad of medical, social and financial problems can trouble the chronically ill child and his family. The counselor must become familiar with the policies and services of local community resources. It is also necessary that the counselor become acquainted with the general procedures of local hospitals and other health-related facilities. Mental health facilities need to be explored and catalogues for future referral sources. Public agencies such as the local Department of Social Services and Department of Juvenile Services should be examined, as such agencies often provide assistance to both counselor and client.

The counselor must also be able to discuss academic and vocational post-secondary opportunities available to the client. This, of course, requires not only an understanding of academic programs offered by individual institutions, but further knowledge of the degree to which each institution

is equipped to meet the special requirements of a chronically ill student.

It must be stated that "time" plays a critical role in the counseling of chronically ill students. Counselors must become mobile, as home visits replace office visits, and testing must often be arranged outside of the traditional school setting. Since they must be available for home visits, hospital conferences, and inter-agency staff planning sessions, CHIP counselors should carry a greatly reduced case load. Effective counseling with this population requires a long-term approach, often requiring weekly client/counselor sessions lasting 9 to 15 weeks. Also, since counseling with the chronically ill is a "family-oriented" process, it should be realized that additional counselor time is mandated.

Summary

Meaningful counseling with the chronically ill can only be achieved when the individual counselor is provided the flexibility and the time to devote to clients. Such clients should not be engaged unless the counselor has the expertise and the time to follow through with the child and the family. Counseling should never be viewed as short-term because the counselor must always be prepared to proceed with the client on a long-term basis as either the primary source of help or as a consultant to other agencies. Therefore, counseling programs being developed for the chronically ill student must accept a lower client/counselor ratio and be designed to facilitate free mobility of staff. Without both ingredients, the program cannot achieve its full potential.

SPECIAL NEEDS OF CHRONICALLY ILL STUDENTS

When speaking of the special needs of chronically ill children, it should be kept in mind above all else that their needs are the same as healthy children. They, too, need love, family support, independence, vocational planning, full social lives, appropriate educational programs, and everything else that contributes to a fulfilling and satisfying life.

It is in the fulfillment of these needs, that complications arise and restrictions are imposed. Psychologically and emotionally, a long-term illness can be devastating for a child. Writers in the field are unanimous in pointing out the high incidence of poor self-concept, distortions of body image, anxiety and depression among sick children. These problems can be compounded by negative reactions from parents. Shock, refusal to acknowledge the problem, guilt, bitterness, envy and rejection are common family reactions according to Love (p. 27).

Emotional

Many theorists have postulated about the importance of childhood experiences on the development of personality. Travis (p. 57) discusses in detail the disruption of Erik Erikson's stages of development caused by chronic illness. The first task of personality development described by Erikson is basic trust. A child distinguishes the world from himself and learns to trust the world by trusting his mother. However, if the child is constantly in pain or exposed to the confusing stimuli of care in a hospital during his first year, it is difficult for him to learn to trust the world.

The development of autonomy is the task of a child's second year. Anxiety about separation from the mother is thought to be greatest at the

age of two, thus hospitalization can be particularly stressful at this stage (Travis p. 59).

The next stage of development is initiative. This can be a particularly difficult task for sick children to accomplish, because of their isolation. Apathy in connection with school and pursuit of a career are found frequently in chronically ill adolescents.

Industry is the task of children of school age. It is extremely important for a chronically ill child to learn industrious habits because he will be unable to compete physically later in life. The child can achieve this goal by experiencing success in school. Failure at this stage leads to feelings of inferiority, according to Erickson. A child who misses school and falls behind, or feels isolated from his classmates, learns to hate school and feel inferior (Travis p. 61).

The task of adolescence is the achievement of identity. This is when the emotional and psychological problems of the chronically ill child become the greatest. During this time the self-concept is formed. The youngster will feel different and inferior if his experiences have been dominated by the negative reactions of others and the negative perceptions of his bodily limitations. Feeling different is at the bottom of most identity problems in chronically ill adolescents (Travis p. 61). Junior high school then can become the focus of the most serious problems facing the chronically ill. The onset of puberty leaves the personality open and vulnerable to all kinds of experiences. The problems of adolescence compound themselves, and a youngster can get "lost" in a large school. He may be unable to participate in athletics, or he may be ashamed to disrobe in gym class due to sexual immaturity or deformity. He longs to be like others, but he feels stigmatized by his illness. Inability to make friends and inability to

attract members of the opposite sex increase his sense of social isolation.

The stresses of adolescence can manifest themselves in a variety of ways. The youth can withdraw from social contact, sink into depression, or exhibit a number of anti-social behaviors like truancy or fighting to prove his independence. The enforced dependence on parents can bring about family conflict, or the youngster may remain immature and dependent.

Another common reaction of adolescents is to reject their medical regimens to demonstrate their self-reliance. This is particularly common among juveniles with diabetes or epilepsy who, by stopping their medication, bring about a medical crisis. These medical crises can be used by the child to manipulate the family for his own ends.

Social

Loss of social contact can be a major problem for the chronically ill child. As enumerated by Strauss (p. 54) this can be for a variety of reasons and is understandable due to medical crisis, regimens and the time spent on control of symptoms. Also, loss of energy, impairment of mobility, speech or hearing, and disfigurement, can disrupt social relations. Two forces combine and compound the problems of social isolation. As the sick person withdraws, other people may tend to avoid him due to their own discomfort about the subject of serious illness.

Some children have the added disadvantage of being reared in an environment that is too protective. A child that has been sheltered unnecessarily lacks experience in meeting people and behaving appropriately in social situations.

Often due to their own needs, parents, especially mothers, will be overprotective of a chronically ill child, perhaps as compensation for being

unable to raise a "normal" child, or out of feelings of guilt or fear.

In general, the counseling strategy employed is to prevent the social isolation of the child and normalize his life as much as possible (Strauss p. 57).

Educational

Education is no less important for chronically ill children than for healthy children. School does, however, pose some problems for the chronically ill. Frequent absences can cause the student to fall behind in his work and fail to be promoted. This can increase his sense of isolation and make social adjustment even more difficult. Even bright students may find themselves consistently placed with slow learners due to work they missed.

For diseases such as asthma, sickle cell anemia, hemophilia and others, absences tend to last only a few days and occur at irregular intervals. This makes home teaching impractical in most cases. Working on the assumption that the most normal placement is best, regular home teaching would not be advisable in these cases. It is here that the CHIP program can fill a huge void for these students, by coordinating between school and the home and providing remedial instruction where necessary.

Problems other than absences also arise at school for some chronically ill students. Fatigue may prevent children with kidney disease, leukemia, heart disease and cystic fibrosis from engaging in a normal school program. In these cases a limit on school activity or distance traveling to classes may be enough adjustment to keep the student in a regular program. Perhaps a half-day schedule with home tutoring need be arranged. It must be kept in mind that each student is different, and his program should be arranged

to meet his individual needs.

Different diseases bring up different needs, some of them complex. It is easy to blame failure in school on the fact that the child is chronically ill; it is much more difficult to accommodate the school program to the stimulation of abilities he presents (Gowan p. 7). School is extremely important to these children as a means of social contact, as enrichment and as an avenue to success and recognition that plays such an important role in personality development.

Medication

Medication can be another source of difficulty for chronically ill children. Drugs can cause a variety of side effects, including nausea and drowsiness. The chronically ill child who continually falls asleep in class or is often too tired to complete his assignments should not be considered lazy or neglected.

A regimen can be worked out to minimize the consequences of side effects so the child can spend as much time in school as possible. Schools with nurses have a great advantage in these cases by having a qualified person on hand to monitor the medication. Teachers should be aware of the possible reactions to medication among their students. The school nurse should be used as a resource person by teachers when questions about medication arise. Classroom teachers observe their students over a long period of time and are often the first to notice changes in behavior due to medication. The CHIP counselor can be instrumental in working with the nurse and other school personnel to set up an appropriate regimen for the ill child.

Another common problem among chronically ill children is the misuse of medication. As previously mentioned, adolescents frequently fail to

follow their regimens and precipitate a medical crisis.

Some chronically ill children may do just the opposite and overuse certain drugs. Drug abuse is frequently encountered among people taking pain killers for diseases such as hemophilia and sickle cell anemia.

The CHIP counselor should be knowledgeable in working with students with drug abuse problems and with students who are having difficulties following their medical regimens. Generally the child should be given as much responsibility as he can safely handle concerning his medicine.

Vocational

Vocational education and career planning are extremely important for all students, including the chronically health-impaired. Satisfactory work adjustment should be one of the major goals of counseling with handicapped individuals. Chronically ill youngsters do have some special concerns relative to career education. These students should be provided with the opportunity to understand the role of work in society and the range of their opportunities (Neal and Neal p. 184). Travis (p. 69) however, raises the question of whether career education is appropriate in cases where the children's disease is fatal. Handicapped students often need to learn basic survival skills of daily living and adaptability. By becoming aware of their own strengths and weaknesses these students can help to build positive self concepts and learn employment skills (Neal and Neal p. 101). Vocational choice is affected by self-discovery, so vocational education should begin early in junior high school at the latest. Students should be allowed the opportunity to explore possibilities within their individual limits (Travis p. 315). In most cases chronically ill youngsters will need employment that is not physically strenuous.

Unrealistic vocational goals are not uncommon among chronically ill students who may either deny their handicapping condition or simply be naive about requirements of the tentative career choice. Another concern counselors of chronically ill children may encounter is the work concept of the parents. The parent whose own needs force him to keep the handicapped student dependent may block movement toward work, since this is a step toward independence. The opposite extreme is also possible if the parent pushes the student toward work before he is ready (Merachink p. 42).

Vocational guidance should be a long-term, on-going process, woven into the total education of the child (Gowan p. 8). One-time programs like career days are not sufficient in themselves to provide the exploration needed or to develop healthy self-concepts in chronically ill students.

Summary

Chronically ill children have long seen many of their needs go unmet. Innovative programs coordinating medical and educational services with the specific needs of the child and his parents, along with a little understanding, can go a long way toward filling this void.

The CHIP program provides a number of services which help greatly in lessening the impact of chronic illness, and the counselor serves a number of important functions. Primary among these is helping the child learn to live with his illness and help him work through the depression and fears that naturally accompany it from time to time.

In conjunction with his work with the student, the CHIP counselor can act as a consultant to provide the family with a vital link to medical, social, educational and vocational resources. To be effective in working with this clientele, the counselor must be able to recognize these needs and then deal with them as they arise.

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THE NEEDS OF THE FAMILY

Families with children having chronic illnesses are confronted with numerous emotional problems. Each family must find its own pace in coming to terms with the agonizing truth that their child's health is impaired. Often parents cannot bring themselves to face the reality of this impairment. As a result they may neglect to seek the help they need, or they may go from one doctor to another seeking a more favorable diagnosis.

McCollum (1975, p. 1) states that it is natural for the parents to want to discredit the doctor's diagnosis, to prove him wrong and be able to find another answer. Why should parents be docile in accepting disturbing news such as this? She goes on to state that one of the most important elements in meeting the challenge of the chronically health-impaired child is a sense of trust in the doctor. If there are doubts, they should be shared with the doctor who should understand and perhaps suggest consultation with another colleague to put the parent's mind at ease.

Grief

One of the many emotional reactions that families experience is grief as related to loss--loss that has occurred due to the child's impairment, loss that is anticipated or loss that is feared.

Grief, according to McCollum (1973, p. 60f), is inevitable for the family of the chronically health-impaired child. The grief is not only for the danger of the child's health, but also for the dreams and aspirations parents have set. Some parents ask themselves, "Can my child have a future?" "Will he ever be independent?" Hopefully, parents will gradually realize that these dreams and aspirations will need to be modified, perhaps even drastically changed, reduced or forgotten. Grief is prevalent throughout the child's illness, in the beginning and again when parents must face the

changing phases of the child's illness.

Grief is a combination of feelings. McCollum (1975, p. 4) states that grief is wild despair. Grief is bitter remorse. Grief is burning anger, clutching fear. Grief is sorrow. Parental grief in dealing with the chronically ill child can be so severe that both parents lose sight of everything else in life including their marriage, other siblings, relatives and friends.

In counseling these parents, it is important for them to be made aware that grief is related to loss, and for this reason a sense of warmth and togetherness is needed for comfort. Grief should be shared openly and outwardly to relieve the intensity. This can be done through verbal expression or tears.

Fear

Another emotion that families encounter is fear. "Can I survive this burdensome mental strain?" Fear can manifest itself in a number of ways. An example is the mother of a child with cystic fibrosis who administers postural drainage to clear the lungs several times a day and forgets where she puts things. She may have no idea where to find them. The father may scold the other children for no apparent reason. Intense emotions accompanied by this mental change can be very frightening for parents.

Fear brings on feelings of helplessness from the parents' standpoint. Their hands are tied. There is nothing they can do to protect their loved one from this dreadful illness. By the same token some parents feel as if the child's entire life is in their hands. They must be with the child constantly. They must administer the medication. They must regulate his activity. They may ask themselves "Am I doing this right?" Am I doing too much or too little?" What if I do something wrong and my child

is put in danger?"

It is just as frightening to feel helpless as it is to feel you must do everything for your child. These are all natural reactions that parents will experience frequently. The Chronic Health Impaired Program (CHIP) counselor must be prepared to help the family deal with these reactions.

Anger

Parents of a chronically health-impaired child experience periods of anger. They become angry with their partners in the mistaken belief that the disease was inherited entirely from the spouse. It is also common for parents to feel anger because they did not seek medical advice when they initially suspected abnormalities in the child.

Marital Strain

Coping with the needs of the chronically health-impaired child can put a tremendous strain on a marriage. Many fathers are absent when the chronically ill child is seen at the hospital. Perhaps because of their emotional vulnerability, they are unable to cope with the stressful ordeal and deliberately avoid these visits.

Some fathers work two or more jobs. There could be several reasons for this. One reason may be to earn more money in order to meet the cost of treatment for the child, or they may feel the necessity to overwork in order to relieve the tensions they are experiencing associated with the child's illness. On the other hand, the mother may be overly protective and insist upon performing these tasks alone, forcing the father to withdraw.

The CHIP counselor's role in instances such as these is to keep communication open between both parents. Parents should be able to share their worries concerning the child's illness. It tends to lighten the

emotional burden and deepen the marital relationship.

Sibling Relationships

Some parents can become so involved in catering to the chronically health-impaired child that they become lax in attending to the needs of other siblings in the family. This can produce feelings of jealousy and resentment. These attitudes drastically affect the sibling's social life. They may not be allowed, or may not want to have their friends over to play. This is especially true if the chronic illness has visible symptoms, such as, cystic fibrosis or epilepsy. Also as a method of getting attention, siblings may let school progress drop or become very irritable. Attitudes such as these can be responsible for fostering negative attitudes toward the chronically health-impaired child.

It is the responsibility of the CHIP counselor to help parents change these negative attitudes by encouraging the siblings to participate in the care of the sick child. Open communication between the parents and siblings is a necessity. Positive as well as negative feelings should be voiced. This leads to better understanding between both parents and siblings. It can result in more positive feelings all around and lead to a higher self-esteem and a sense of accomplishment on the part of the sibling.

Financial Needs

Financial needs of parents with a chronically ill child can be quite burdensome, however, the needs vary according to the severity of the illness. For instance, children with cystic fibrosis require constant care. One parent must stay home in order to administer the postural drainage which is done at least twice a day. Special diets and extra vitamins are required to help him grow and digest food.

This can be quite difficult for those on a limited budget. One parent may have to take two jobs in order to meet the cost of medicines, inpatient treatment, regular check-ups and routine x-rays (Burton p. 19).

Burton also lists the actual strains caused by this disease:

1. The cost of transportation to the out-patient clinic.
2. The additional cost of feeding a frequently hungry child, who in some instances requires a high protein diet.
3. The cost of extra clothes.
4. The loss of earnings occasioned by absence from work when the child is sick.
5. Additional expenses such as increased electricity charges due to running the mist tent.

As stated before, the financial needs will vary depending upon the severity of the illness, and no two cases are identical.

In our experience with inner city youth, the following financial strains are prevalent:

1. The high cost of medical expenses.
2. Possibility of medical insurance being dropped or denied due to severity of the illness.
3. Difficulty in obtaining Supplemental Security Income. (SSI is a federal program which provides income to persons of any age who are blind or disabled.)

Summary

The CHIP counselor must be flexible in dealing with the needs of families of the chronically health-impaired child. He must be his 'Rock of Gibraiter', yet keenly sensitive to his needs. He should be the agent in changing negative attitudes developed as a result of the child's illness. Acting as a consultant to doctors and relatives is a major responsibility of the counselor in helping these persons understand the emotional, psychological and financial fears of families with chronically health-impaired children.

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THE CONSULTANT ROLE

The Chronic Health Impaired Program (CHIP) counselor provides support services. When working with a school, he must be attuned to the school setting. This means that he must adapt to the particular student personnel or guidance program. He gives input when needed, and as a consultant his suggestions can be invaluable.

Recognition of work done by community agencies is important to the CHIP counselor. It is necessary that these services work together harmoniously. The counselors of the program, because of their training and sensitivity to attitudes are in a good position to work toward the development of genuine cooperation. Such cooperation must be built on mutual respect.

The case of James Booker illustrates this concept. James, a 17 year-old student, was having problems making adjustment upon his return to the community from a correctional institution. Because of illness, he was eligible to receive the services of the CHIP program. His juvenile worker suggested he return to his original school, but she was not sure if this would be the proper placement. The CHIP counselor requested that James be given a battery of tests to determine his current needs. It was discovered that James was reading at second grade level and functioning at a third grade level in spelling and math. In sessions with the counselor, James also displayed a high degree of anxiety relating to his incarceration. Because of his performance on the achievement test, the CHIP counselor felt James' previous school would not meet his needs. A school offering a curriculum that stressed functional reading and math and a work-study program was recommended.

James was placed at a special school and is meeting with success for

the first time in many years. In the work-study program he has gained a more positive attitude about school and himself. His juvenile worker was also satisfied with his progress.

Each situation handled constructively strengthens the links of cooperation. There is little chance of jeopardizing the student or his relationship with other helping agencies if open communication prevails.

Cooperation is enhanced when each professional assisting a student focuses on his role and recognizes his limits of intervention. Very often the CHIP counselor is part of joint staff meetings organized around individual cases. If he is asked only for his professional opinion of a case, then that should be the limit of his interaction. The general discussion and the sharing of information leads to a deeper understanding, not only of the student to be reached, but also of others present. It is an indispensable part of the process in team undertakings. Through the cultivation of mutual respect and the development of communication channels, counselors and other professionals can learn to cooperate effectively.

The CHIP counselor does meet opposition. Confrontations with negative attitudes from others may arise. In one case, a counselor at a secondary school was vehemently opposed to a student receiving CHIP services. This counselor felt that the student was abusing the services of the CHIP program.

The student's illness did keep him home a great deal during the winter months. The school counselor and the child's teacher did not realize the severity of the symptoms of sickle cell anemia. Upon making this discovery a survey was initiated by the CHIP counselor to see if a workshop would benefit the school staff.

The workshop proved highly successful. It promoted a better understanding of the purpose of the CHIP program, and an effective working

relationship between the CHIP program and the school was established. Also, a clearer idea of the role of the CHIP counselor and the functions of the CHIP teachers were developed at the school. As a result, school personnel grew more sensitive to the special needs of chronically ill children.

If the CHIP counselor is to be effective he must solicit the understanding and cooperation of agencies that are also working with his students. This must be an on going process, requiring the attention of all who work in the CHIP program.

CASE STUDIES

Five case studies are presented here to illustrate some of the problems faced by and the techniques used by counselors in the Chronic Health Impaired Program (CHIP).

In the cases of Mary White, Jane Jackson and Kathy Smith, the counselor was originally faced with the same problem. The dynamics and outcomes of these cases turned out to be much different, however.

Zeke Brown's case demonstrated the long-term nature of counseling with the chronically ill. It also illustrates the need for cooperation among many agencies and institutions and the CHIP counselor's role in coordinating a number of services.

The case of Shirley Jones is presented as an example of the difficulty involved in changing long-established patterns of behavior and family interaction.

STUDENT'S NAME: MARY WHITE

PRESENTING PROBLEM: ASTHMA-POOR SCHOOL ATTENDANCE

Mary is a nine year old living in a foster home. She was initially referred to the Chronic Health Impaired Program (CHIP) by the school nurse. Mary was suffering from a very severe asthmatic condition which caused her to miss school frequently during the cold weather months. As a result her academic achievement had dropped considerably.

A teacher working at Mary's school was assigned to service her on those days when she was out due to illness and also to provide remedial assistance two times a week in an effort to raise her academic achievement. Through the part-time teacher, other problems were revealed which necessitated further investigation.

The teacher stated that the guardian was not very receptive to her home visits when Mary was ill. The case was then referred to the counselor. I called the guardian, Mrs. Tack, to set up an appointment for a home visit.

Mrs. Tack seemed to be quite receptive to my visit. She began by stating that she did not want anyone coming to the home to service Mary. I immediately asked her reasons for making that statement. She replied that Mary was always upset after the teacher left. She felt that the teacher pushed her to the point of frustration, upsetting her and bringing on an attack. In addition, Mrs. Tack felt that the teacher was not sensitive to Mary's needs as far as her illness was concerned. She said the teacher knew nothing about students with asthma and what precipitated an attack.

We both reviewed Mary's grades and agreed that she was far behind and was definitely in need of additional help both in school and when she was out sick. After a little persuasion she decided to give it one more try. This time I suggested we use one of the full time teachers in the CHIP

program. Mrs. Tack was in agreement.

Mary was out sick one week after our conference. The new teacher had been assigned and did visit the home. Upon entering the home she was greeted by Mrs. Tack who stated Mary was in fact ill and did not want the teacher to upset her in any way. After the lesson, Mrs. Tack seemed to be quite pleased. She told the CHIP teacher that she would like her to return and work with Mary.

Mary continued to make little progress in spite of additional support services from the CHIP teacher at home and the classroom and resource continuum teachers at school. The teachers agreed that Mary's poor attendance was the main problem. This was compounded by the fact that she was a slow learner and needed a great deal of continuity in her lessons, something she was not getting at present. It seems that the guardian would keep the child home if it looked like it was going to rain or if she thought it was too cold.

I talked to Mary's doctor who stated that she should attend school as much as possible and only stay home in cases of actual illness, not simply because of the weather.

I visited the home again to express our concerns about Mary's attendance. We reviewed the functions of the program and responsibilities of the guardian. Her responsibilities included sending Mary to school when she is feeling well, and not keeping her home simply because the weather is bad, especially since Mary has special transportation to and from school. I also suggested that when Mary is out due to illness, she should be taken to the doctor to get documentation that she was seen by medical personnel to avoid the possibility of a truancy investigation.

I also stressed the importance of Mary attending school as frequently

as possible not only for academic improvement but for more positive peer social interaction. Until this point Mary's peer interaction had been limited only to when she attended school, which was seldom. Mrs. Tack felt that children in the neighborhood were too rough and that Mary's medical state warranted as much rest as possible. Mrs. Tack showed genuine concern for Mary's health. She stated that she cared very much for Mary and was doing everything humanly possible to make life easier for her. I assured Mrs. Tack that the CHIP program also had Mary's best interest at heart and that we wanted her to participate in activities other children her age were involved in. I recommended that she let children living in the neighborhood come in and play with Mary, or perhaps enroll her in the Brownies or some other youth organization. I also suggested that as a parent she might become involved in community activities.

Mrs. Tack is now a leader for a Brownie troop and is also an active member of a small community organization in her neighborhood. Mary began attending school on a regular basis and has shown some improvement in her school work. In addition, her social skills have improved. Hopefully, with continued support from the classroom teacher, home teacher and parent, Mary's grades will improve.

STUDENT'S NAME: JANE JACKSON

PRESENTING PROBLEM: ASTHMA-POOR SCHOOL ATTENDANCE

In November 1975 Jane Jackson was referred to the Chronic Health Impaired Program (CHIP) by a local hospital clinic due to her asthmatic condition. Jane is a ten year-old from a blue collar neighborhood. She is an only child and lives with her mother and grandmother.

In the initial referral the doctor stated that Jane's asthma was fairly well under control with medication, and she should miss little time from school. Her attendance improved toward the end of the year, and she was promoted to the third grade.

During the 1976-77 school year, Jane's pattern of poor attendance continued. In addition, her absences were often not reported to the CHIP teacher by Jane's mother.

Jane was referred for counseling by her CHIP teacher who stated that Jane was far behind in her school work due to her frequent absences, and because the parent was not contacting the CHIP teacher when Jane was absent.

I contacted the mother at home to relate our concerns about the frequency of Jane's absences and to stress the importance of the CHIP teacher being notified on these days. At first Mrs. Jackson stated that she was no longer interested in receiving CHIP services. When asked to explain, Mrs. Jackson hesitated. Later she expressed dissatisfaction with Jane's CHIP teacher, who she said had not cooperated with the family.

She did agree that Jane could profit from CHIP services. I said that I would look into the possibility of assigning a different CHIP teacher to Jane, and Mrs. Jackson stated she would gladly work with another teacher.

A few weeks later, a different CHIP teacher was assigned. During

the remainder of the school year, Jane's attendance improved slightly, but her mother did call the CHIP teacher when Jane was out of school, so she was able to keep up with her classwork.

At the beginning of the 1977-78 school year pupil services started monitoring Jane's attendance for a possible truancy investigation. This was done at the suggestion of the CHIP program, because Jane's attendance had not improved sufficiently, and she did not seem so ill that she should miss so much time.

During the fall of 1977, Jane's pattern of attendance continued to deteriorate. Often she would stay home for a week at a time without contacting the CHIP teacher.

I contacted the family to make a home visit and have a conference with the mother. I advised Mrs. Jackson that there was a very good possibility that Jane would fail to be promoted because she was now missing almost 75 percent of school, and because the CHIP teacher was not being informed of her absences. Mrs. Jackson suggested that a permanent home teacher be assigned. I explained that this is rarely done for children with asthma unless it can be proven the case is very severe.

Since Jane was home, I went to her room to say hello. She was sitting up in bed watching television and did not appear to be sick, even though she had been absent three consecutive days.

Before leaving I reminded Mrs. Jackson that unless Jane's attendance improved to better than 50 percent, Jane could be dropped from the CHIP program. She said she knew Jane missed a lot of school, but Jane was weak and the absences were all due to illness. I suggested that the nurse assigned to the CHIP program could possibly help and that I would see if she could make time to see Jane.

The next day the CHIP nurse made a visit to the Jackson home. Jane was still home along with her grandmother. The nurse examined Jane and found nothing wrong. She reinforced the program's concern about Jane's health and attendance to the grandmother.

The following week a conference was held concerning Jane. In attendance were her CHIP teacher, the nurse, the program coordinator and myself, the counselor. We were all in agreement that the Jackson's seemed to be over-protective of Jane and were abusing the CHIP program by the number of unwarranted absences and by not informing the teacher when Jane was out sick.

It was decided that CHIP services would continue only if certain conditions were met: 1. Jane should be re-examined by a doctor, and the family should have the doctor submit a new request for services. 2. She would receive CHIP services when she misses school only if she is seen by a doctor. 3. Her attendance would continue to be monitored and should show improvement.

On November 10, 1977 a letter was sent to Mrs. Jackson and to Jane's school principal explaining these conditions of service.

Within a week a referral form on Jane was received from a different doctor. However, no address was given for the doctor and no doctor by that name was listed on the staff on any local hospital or with the medical association.

A check of Jane's attendance on December 5th showed no improvement, and there were no other recent doctor's notes to explain the absences. On December 15, 1977 CHIP services were terminated for Jane Jackson.

STUDENT'S NAME: KATHY SMITH

PRESENTING PROBLEM: ASTHMA - POOR SCHOOL ATTENDANCE

Kathy is a 14 year-old junior high school student. I began my involvement by contacting Kathy's school, where I learned that she had not attended school since the second week of September. The school staff said that Kathy had experienced several severe asthma attacks during the first week of school. In fact, the school had been forced to transport the girl home on several occasions.

I then contacted the parents and arranged for a home visit. I visited the home, a small row house in one of the poorer neighborhoods, where I met both Mr. and Mrs. Smith, Kathy and the younger daughter. The family seemed very receptive to my visit. I began by asking a number of questions aimed at getting a clearer understanding of the history and magnitude of the problem. Mrs. Smith began answering; however, within a short time, Mr. Smith took over the dominant position and remained in "control" of the entire session. Kathy was totally non-verbal and seemed threatened by my presence.

I then made an appointment to speak with the doctor and a psychiatric nurse practitioner, who had a great deal of contact with Kathy and her family. The doctor described Kathy's condition as being severe; one of the worst asthmatics he had seen. The nurse described the girl as highly emotional, the father as seductive, and the mother as passive.

Within a few days I began meeting with Kathy individually and I also began seeing Mrs. Smith. Interestingly, I found both to be very verbal.

While Kathy had been totally non-verbal in the presence of both parents, alone she began talking almost non-stop. In fact, after an hour and a half, I had to close off further discussion. It was evident that Kathy

had a great deal on her mind. It was also clear that she felt inhibited by either one or both of her parents.

During our first individual session, I learned that Kathy's father had been out of work since the middle of September. Apparently he had been involved in a golf accident, which had injured one of his legs. It should be noted, however, that I was not able to observe any injury during my initial session with the family. Also during my first private interview with Kathy, I learned that she had strong negative feelings towards her mother. She described herself as her mother's "slave". According to Kathy, she was expected to assume most of the household responsibilities, including the care of her younger sister. My later contact with the mother demonstrated that this was, in fact, true. Mrs. Smith reported that she had actually turned over most of her duties to Kathy, and that she felt tremendous anger when Kathy failed to fulfill these tasks. Kathy described the mother as violent, at times throwing objects about the house.

Kathy agreed to begin seeing me on a weekly basis as did Mrs. Smith. Both seemed eager for my help, and both remained conscientious in keeping their appointments. I met with Mrs. Smith at the home, while seeing Kathy at the school. It should be pointed out that Kathy returned to school three days after my first visit, and she quickly established a pattern of regular attendance.

Shortly after my initial involvement, I was contacted by a doctor from one of the major hospitals and asked to sit in on a conference that was to be held regarding Kathy Smith's case. Apparently, the hospital staff had taken an interest in the case, due primarily to the unusual circumstances surrounding the case:

1. The fact that the girl had shown no signs of asthma prior to the age of 12.

2. The inability to bring the asthma under control.

3. The severity of the asthma attacks.

The hospital was not aware of the family dynamics described earlier.

At the conference I presented the material I had learned through the process of personal interview. In addressing the group, I suggested that the profile I was describing seemed much like that of a dysfunctional family involved in possible father-daughter incest. While there was currently no solid evidence, many of the more common incestuous dynamics were present in this family:

1. Mother/daughter conflict.

2. Mother's willingness to permit the daughter to assume primary home management responsibilities.

3. Daughter's reluctance to attend school.

4. Excessive father/daughter contact, resulting from father's unemployment status and daughter's lack of school attendance.

5. Mother's violent episodes, generally triggered by mother/daughter exchanges.

6. Mother's "eagerness" for personal counseling.

7. Daughter's inability to verbalize feelings in the presence of either parent, yet anxious to talk with a stranger.

My suggestion of an incestuous relationship was well received. Many of those directly involved with the case had suggested incest, but were unable to express their own concern with others. It was as though they were relieved by my open suggestion of the possibility of incest.

After hearing all of the parties involved, the psychiatric consultant agreed with my findings and added that the asthma could easily have developed as a protective mechanism for Kathy. Kathy can use the asthma condition to ward off advances by her father, and at other times, such as at school, she unconsciously might employ the asthma as means of being able to leave

the school to be with her father. Further, the asthma might well be viewed as a cry for help, perhaps hoping that someone might identify the incest.

Following the hospital conference, I met with Kathy, and I began to focus much of the conversation on Kathy's relationship with her father. She was at first, very reluctant to talk on this topic, but my persistance paid off. She soon began to openly discuss her relationship with him. In fact she began testing me by giving me pieces of information which suggested incest and watching my response. It was clear that she wanted to share the experiences with me but was experiencing a great deal of pain because of this inner conflict, to tell or to keep the secret. By letting her know that I wanted to help her and that I genuinely cared about her, I was able to give her the permission she was seeking. Suddenly, bursting into tears, she began describing how her father had been having intercourse with her for the past two and one-half years, and that the intercourse had been preceeded by three years of performing oral sex on him. She went on to say that, while her mother had never said anything, she felt sure that her mother knew about the incest.

After nearly two hours of tears and peaking emotional outbursts, Kathy was able to calm herself and gain control again. She was suddenly very frightened at the realization that she had told someone and begged that I not tell anyone. I told Kathy that because I cared about her and because I wanted to help her, I had to report the incest, but that I would stay with her throughout the entire affair. While she still asked that I not report, she did find comfort in my assurance of support.

I then took Kathy home, where I met her parents. I confronted the parents with the incest and expressed both my concern and my legal obligation to file a report. Initially both parents denied the incest and became furious

at Kathy. However, as I continued to discuss the facts, as they had been related to me, Mrs. Smith began to cry as did Mr. Smith and Kathy. It was apparent that the truth had finally surfaced.

After several minutes of silence, and without any real confession, Mr. Smith asked, "What's going to happen now?" I explained that I would contact the Department of Social Services (D.S.S.) who would respond to the household within 24 hours. I advised Mr. Smith of the legal issues involved, and that he should expect charges to be brought against him.

Under tremendous stress, Mr. Smith seemed to fluctuate between admitting his part in the incest situation, and totally denying any part in the incident. Again, I continued to reassure him that my intent and that of D.S.S. was to help him and his family, not destroy them. This reassurance had only a momentary calming effect. He did, however, realize the importance of talking with Legal-Aid.

Shortly after my formal report to D.S.S. it was agreed that Kathy should remain home, and Mr. Smith would temporarily move in with relatives. At my request, D.S.S. agreed to permit me to be the primary treatment source for Kathy, and further agreed to hold charges against Mr. Smith pending his own involvement in therapy. I agreed that incarceration would cause an additional burden to Kathy, her mother, and the other siblings, since Mr. Smith was the primary income source. He had just recently returned to his former place of employment.

My subsequent sessions with Kathy focused primarily on getting her in touch with her own feelings and attacking her feelings of guilt and shame. In later sessions, we dealt with her self-image concepts, and her expectations of herself and of others. It was apparent that Kathy had developed a distorted self-concept and had established unrealistic

and unnatural expectations of others. Much of our time was devoted to looking at what is normal and what is not. Kathy's parenting models had not been able to present a normal behavior, and, therefore, Kathy had not adopted realistic concepts of normal behavior. Our sessions sought to let her examine other behavior and models.

Particularly helpful in the treatment plan was the fact that Kathy re-entered school immediately after our initial contact. This provided Kathy with:

1. a retreat from the home environment.
2. much needed peer contact.
3. other adult models.
4. a vehicle to demonstrate self-worth through academic achievement.

I should report that Kathy has now achieved a pattern of 100 percent attendance, has demonstrated exceptional ability, and is well liked by both her teachers and her peer group. Clearly the school environment has become a vital role in the treatment plan.

Although initially reluctant, Mr. Smith is currently involved in long-term counseling. Because of his involvement in therapy, an agreement was reached between Legal-Aid and the District Attorney's office not to prosecute.

Mrs. Smith has expressed strong desire to work toward a complete reuniting of the family. After two months of therapy, she confessed that much of the problem was her direct responsibility. She too is troubled by feelings of intense guilt.

Although unable at first, Mr. and Mrs. Smith are now also engaged in group marital counseling. Reports received thus far indicate slow progress, but strong desire for reunion seems to be present.

Finally, my work with Kathy has shown gratifying progress, not only as

demonstrated by the school environment, but especially in areas of personal growth and maturation. Kathy is now able to "like herself," although her feelings of guilt and shame still occasionally surface. In addition, her asthma symptoms have disappeared.

This case demonstrated that abuse cases need not always be destructive. The family was cooperative throughout, and much of the cooperation, I believe, stems from the approach used. I was always cautious not to become a threat to the family, and to maintain the posture of a helper, someone genuinely concerned with their welfare.

Credit must also be given to the Department of Social Services and the District Attorney's office for their therapeutic, rather than punitive, approach to the case. This position was made possible because other resources were available to help this family.

STUDENT'S NAME: SHIRLEY JONES

PRESENTING PROBLEMS: EPILEPSY - REQUEST FOR HOME TEACHING

My contact with the case began when Mrs. Jones, Shirley's mother, called requesting full time home teaching for her daughter. Shirley is a 17 year-old student at a vocational high school for intellectually limited students. Shirley had been absent from school for almost two months, and she had had no seizures during this time.

I contacted the parents and arranged a home visit. They lived in a small row house in a poor neighborhood. During the initial home visit Shirley seemed timid, helpless and lacked self-esteem. She had not attended school because she felt disliked by both teachers and peers. The student said she especially disliked her homeroom teacher. Her mother and grandmother were concerned about her safety at this school because the students were too rough. The mother and grandmother were anxious to have Shirley placed on home teaching. Because the seizures were under control, there was no need for home teaching and the request was denied. Shirley was eligible for services of the Chronic Health Impaired Program (CHIP).

Shirley seemed spoiled and overprotected by her maternal grandmother, Mrs. Wilson. Mrs. Wilson seemed overly involved with the entire family system, especially the grandchildren. The impact of Shirley being over-protected is carried over into her relationships at school and with peers. Shirley seemingly expects the same attention she receives in the family environment in the outside world.

There existed a rigid boundary between Shirley and her mother. Shirley has lived with her grandparents since birth. Mrs. Jones revealed that her mother constantly sabotaged any rules that she set for her daughter. Mrs. Jones was never allowed to take parental responsibility. Grandmother

stated that she tries to compensate for the closeness that does not exist between Mrs. Jones and her daughter. The father and grandfather are peripheral in the family system. During the home visit, Mr. Jones sat in back of the counselor. He finally walked to the far end of the room, where he stood looking out of the window with his arms folded. The grandfather and siblings were not invited into the family discussion.

The student does not attend school when she complains of illness. She uses her epilepsy to avoid attending school. When she is in school, she manipulates the situation to get out of academic activities.

A meeting was scheduled with the principal, homeroom teacher, school counselor and CHIP counselor to coordinate educational services for the student. It was decided that Shirley should report to the main office if she encounters any peer problems she feels incapable of handling, because she said that a group of students had tried to fight with her. The CHIP counselor would continue as primary help resource for the student and family. Shirley returned to class with her homeroom teacher the same day and asked her teacher for additional help to make up for the lost time.

Shirley moved out of her grandmother's house and home with her mother. The parents requested family counseling, and an appointment was scheduled for the following week.

Mrs. Jones cancelled the appointment and the student missed three days of school because of illness. I advised the mother to contact the homeroom teacher as soon as possible. Shirley missed an additional week and a half of school because of a strep throat infection.

I met with the student briefly to reinforce her efforts to make up all of the classwork she had missed. Shirley had successfully met with all but two of her instructors. Shirley cried and expressed her frustration

in trying to handle this situation alone. I encouraged the student to talk with the two teachers with whom she had problems. She accomplished the task and seemingly gained self-confidence.

Mrs. Jones does not feel that family counseling is necessary because she felt Shirley was doing well in school. Shirley was successful in obtaining a summer job on her own. Mrs. Jones called expressing concern because the job was dirty and asked if the student could be placed in a cleaner job. I assured her that any attempt on Shirley's part to initiate an activity on her own was positive. Shirley did not know how to ride a bus alone, but I convinced Mrs. Jones to walk through this activity (to and from the work site) with Shirley.

A week later I telephoned Mrs. Jones to remind and encourage her to keep the appointment scheduled with the Division of Vocational Rehabilitation (DVR). The agency would assist the student in obtaining additional training after graduation. Mrs. Jones assured me that she had made several attempts to reach the DVR counselor who never returned her calls. The DVR counselor had never received any calls from this family, and they never showed up for the scheduled appointment.

Shirley was not promoted to the next grade and her mother called me for assistance. I called the school principal. He said the student had put forth little or no effort to pass this semester and had continued her pattern of poor attendance. I relayed this information to the mother and scheduled the family for counseling. When I arrived for the home visit, no one was home. The next day I telephoned Mrs. Jones. She said she was visiting Shirley's grandmother and assumed that I would know this.

My work with the Jones' has so far shown very little progress. The student has moved back to the grandmother's house. Mrs. Jones does not

want to take the responsibility for her daughter, and the family is seemingly not ready to make changes.

Family counseling is advised in this case, and a session is scheduled for next week. I am hopeful progress can be made, especially in helping Shirley become more self-reliant. The family has been irresponsible about keeping appointments, however, so the prognosis for success is only fair. If family counseling does not not work out, individual sessions with Shirley to help her become a more independent adult seem in order.

STUDENT'S NAME: ZEKE BROWN

PRESENTING PROBLEMS: SICKLE CELL ANEMIA - FIGHTING

Zeke is a 17 year-old black male with sickle cell anemia. He lives in a public housing project with his mother, brother, 16, and sister, 14. Zeke is in the ninth grade.

A new school year had started when I received a call from Zeke's junior high school counselor. She indicated that his attendance was sporatic, and he was having problems at home. A home visit seemed in order, that Zeke had been using obscene language, fighting and had had to be restrained. He was sent to an aunt's house for a cooling-off period. I assured her that sending Zeke to his aunt might have been the best thing for awhile.

The following day I stopped at Zeke's school during the lunch period. He seemed very surprised to see me. Zeke did most of the talking, and in the conversation he confirmed all that was said by his mother. He seemed rather resentful as he related the details and said he felt that nothing was going right in his life. When the class bell sounded, I told him I would see him the following week. If something came up, he should call me at the office.

The following week Zeke's mother called. Zeke had returned home and had started fighting again. This time he had to be taken to the hospital, because he began to have a sickle cell crisis. While at the hospital Zeke told the staff doctors that his mother had abused him, and the hospital had called the police to investigate the charge. I assured her that I understood what she was going through but that Zeke also had a great many problems. His inability to read, his lack of success in school and his health worried him. He was scheduled for surgery and most likely did not

know how to express his fears and uncertainties to his family.

For the next three weeks I saw Zeke weekly. He had been in school, and he seemed to be making some progress. He mentioned that he would be going to the hospital for surgery, and the doctor wanted him to remain home until that time. He also asked if his CHIP teacher would be seeing him daily, so arrangements were made for home teaching.

A week later a call came to my office. The surgery was to be postponed, and Zeke was upset. Our sessions consisted of understanding what the surgery was about, and how it was going to help him. I went to see Zeke at school, but the vice principal informed me that Zeke had been admitted to the hospital and would be there for four to six weeks. When I stopped by the hospital, I could see the toll this indecision was taking. Two weeks later I got a call from Zeke's doctor. They were going to postpone surgery again.

Zeke's eyes glistened as he discussed his anger, "What were the doctors doing?" Tears came to his eyes as he talked about his plans. He mentioned dropping out of school. We discussed the job market and what it takes to be a self-sufficient individual. Zeke reached the conclusion that he needed a skill and school was the best place to get one.

A few days later I met with Zeke's school counselor. His scholastic record showed a reading level of 2.1 and a 3.2 grade level in math. We were discussing the chances of Zeke's success in various high school programs when we discovered that Zeke was eligible for a special work-study program for disadvantaged youth. Things seemed to be looking up. Our subsequent sessions focused on vocational goals and adjustments to the world of work, because the work-study program would begin shortly.

Zeke was living at home and things seemed calm. In addition, his conduct at school showed marked improvement.

In February a call came from the school. Zeke had been admitted to the hospital in another crisis. A conference with his doctor confirmed my suspicions. Because of Zeke's hip problem and periods of hospitalization, he would not be able to work this year. Zeke was discharged after five days.

After his release from the hospital, Zeke seemed to go into a period of depression. His school attendance dropped and his CHIP teacher reported that he seemed to lack interest. We discussed the numerous stays in the hospital, but he felt he was so far behind it was not worth going to school. When I told him that the work-study program continued in the fall, he smiled and replied, "But will I be well enough?"

During the third week in May I visited Mrs. Brown to get her views on Zeke's progress. Midway through what had been a rather ordinary conversation she revealed that she was a lesbian. This information added new complications to the family dynamics. The rest of the session focused on how this affected Zeke and the rest of the family. Could this be a reason for his acting up? Was his struggle for identity affected by her sexual preference?

I suggested that this question needed to be confronted by the entire family and that family therapy seemed advisable. Mrs. Brown sincerely wanted help and agreed that it was a good idea.

Because the school year was ending and mine is a 10-month position, I said that I could not act as the therapist. Instead I would set up an appointment for the family at a local mental health center.

Two weeks after my meeting with Mrs. Brown, Zeke was admitted to the hospital again for surgery. The doctors had at last scheduled the long-awaited operation. When I saw Zeke he seemed in good spirits. Finally something was to be done. Zeke had made some improvement in his relation-

ship with his family, and he seemed happy about our fall plans. He even mentioned that he wanted to go to summer school.

Much has happened to Zeke this year. Surgery has been postponed five times, and he has had four sickle cell crisis. He has missed more than half the school year and failed most of his subjects. Even though much has gone wrong in his life, Zeke has made progress in some areas. He has been living at home for several months now without serious problems. An important change is that Zeke now holds some hope for the future. He is looking forward to attending the vocational school and joining the work-study program if his health allows it. I will check on his progress when school begins next September.

The family is now engaged with a therapist, and I am hopeful that progress can be made on the difficult problems they face.

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